Medicare Update

Diabetes/Heart Disease & Stroke
Winter Symposium

02/28/09

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Presentation Objective

- Identify appropriate Medicare billable services to ensure uninterrupted revenue streams and maintain administrative compliance
  - PQRI
  - Diabetic Teaching Services
  - E/M

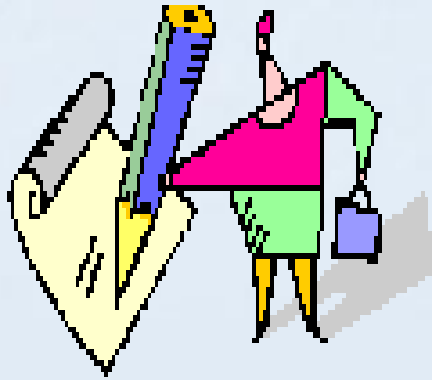
PQRI

- Physician Quality Reporting Initiative

Handout #1 – "Getting Started…"

PQRI Handouts

- Handout #1 -Getting Started with 2009 PQRI Reporting of Measures Groups (pages 1-8)
- Handout #2 -2009 PQRI Measures Groups Specifications Manual
  - TOC (pages 3-4)
  - DM Measures Group Overview (pages 5-12)



Bonus/Incentive

- Report Periods
  - 01/01/09 - 12/31/09
  - 07/01/09 – 12/31/09
- Bonus – 2% of total allowed charges

Bonus Limitations

- Covered professional charges
- Allowed charge
- Longest participating period
- Report 80% of eligible cases
- No partial bonuses

Eligibility

- Part B ONLY program
- Voluntary program
- Valid NPI
- Participating or nonparticipating physicians
- Participating or nonparticipating practitioners

Eligible Practitioners

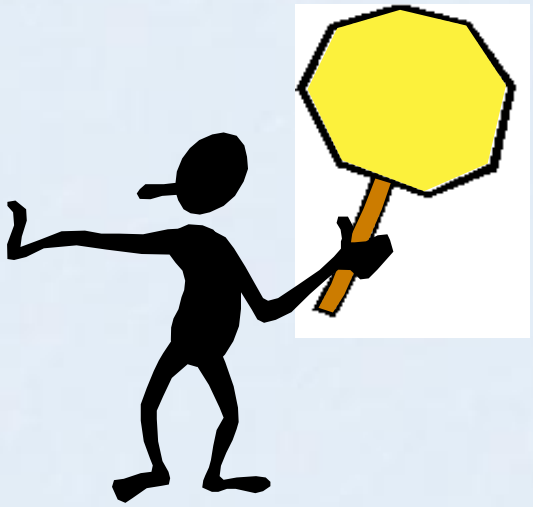
- PA
- NP
- CNS
- CRNA
- Midwife
- CSW
- Clinical Psychologist
- Registered Dietician
- Nutrition Professional
- Audiologist

Limitations

- IDTF, hospital, partnership eligible IF:
  - Physician assigns participation rights to employer
  - Employer reports QI for physician
  - Physician reassigns payment to employer
- Physician-by-physician basis
  - Multipractice groups

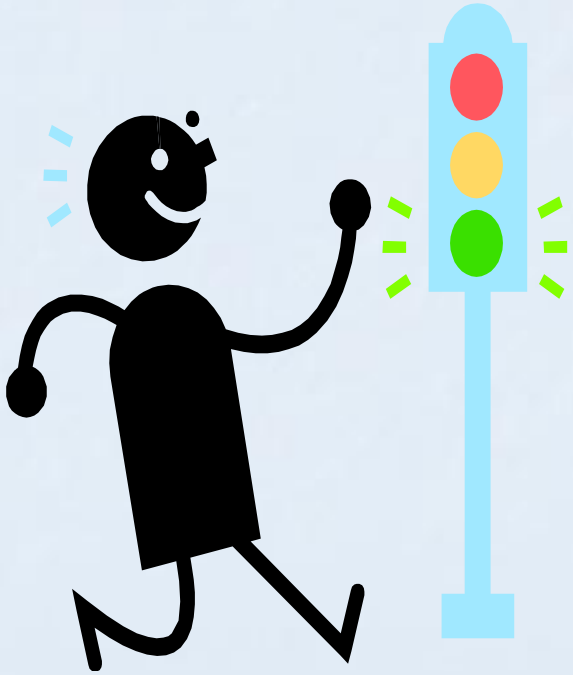
Caution Note

- PQRI transactions are subject to examination
- Report according to guidelines
- Fraud/Abuse standards apply



Participation

- No registration
- Start reporting



Report Options

- Claims
- Approved Clinical Registry
- Individual Measures
- Group Measures

Individual Measures

- DM – 8 individual measures
  - 1, 2, 3, 19, 119, 126, 127, 163
- Stroke – 8 individual measures
  - 10, 11, 31, 32, 33, 34, 35, 36

Handout 2 pages 3-4 (TOC)

Group Measures

Report clinically-related measures

- **Diabetes Mellitus**
- Chronic Kidney Disease
- Preventive Care
- Coronary Artery Bypass Graft
- Rheumatoid Arthritis
- Perioperative Care
- Back Pain

Handout 2 pages 3-4 (TOC)

Report Options

- Diabetes – Individual or Group
- Stroke - Individual

Group Measure Reporting

- Consecutive diabetic patients (15/30 minimum)

OR

- 80 % of diabetic patients seen during period

- Count starts on G8485 submission date
- Submit G8485 once per report period

***G8485:** I intend to report the Diabetes Mellitus Measures Group

Minimum Requirements

- Report **All** applicable measures at least once during period
- 30 consecutive patients (1 year)
- 15 consecutive patients (6 months)
- 80%

Measure Components

- Denominator - eligible patients
- Numerator - clinical action
- Reporting Frequency/Performance Timeframes

Measure Modifiers

- Action not provided/performed due to:
  - 1P - Medical Reasons
  - 2P - Patient Reason
  - 3P - System Reason
  - 8P - Reason not otherwise specified
- May have one or more exclusions per measure
- May not have applicable modifier

Reporting Requirements

- Minimum of 1 CPT code per claim (one service)
- Don't report ONLY quality code
- Quality fee = $0.00 (or $0.01)
- NPI on same line as quality code
- Report quality code modifier as indicated

Group Measure Consecutive Payment Sample

DOS	POS	Code	DX	Fee	Units	NPI
01/01/09	11	99213	250.00	$95.00	1	9999999
01/01/09	11	G8485	250.00	$0.00 or $0.01	1	9999999
01/01/09	11	3077F	250.00	$0.00 or $0.01	1	9999999

Handout 1, p. 6

Source

- CMS home page
  - www.cms.hhs.gov
- Select “Medicare”
- Select “Physician Quality Reporting Initiative”

Diabetes Self-Management Training Services (DSMT)

- Blood glucose monitoring
- Diet and exercise education
- Patient specific insulin treatment plan
- Self-management motivation

Requirements

- Certification by treating physician or NPP
- Maintain plan in MR of treating physician or NPP
- Documented individual need for education
- Number of initial or follow-up hours ordered
- Covered topics

Diabetes Self-Management Training Services (DSMT)

- Certified provider
- DSMT accredited program
- Prescribed by physician
- Performed by qualified staff

Initial Training

- Initial training = 1st 12 months
  - No previous initial or follow-up training
  - Furnished within 12-month period
  - ≤ 10 hours
  - Initial hour usually individual

Follow-up Training

- ≤ 2 hrs individual or group per year
- Limit 2-20 individuals
- At least 30 minutes

Individual Training Requirements

- > 2 months from group session
- Documented special needs
- Additional insulin training ordered

Billing/Coding

HCPCS codes

- G0108 – 6 unit maximum (3 hrs)
- G0109 – 20 unit maximum (10 hrs)

CPT Codes 98960-98962 – Not Covered

DSMT CMS Reference

- http://www.cms.hhs.gov/Manuals/IOM/list.asp
- 100-02 Medicare Benefit Policy Manual
- Chapter 15
- Section 300

Medical Nutritional Therapy (MNT)

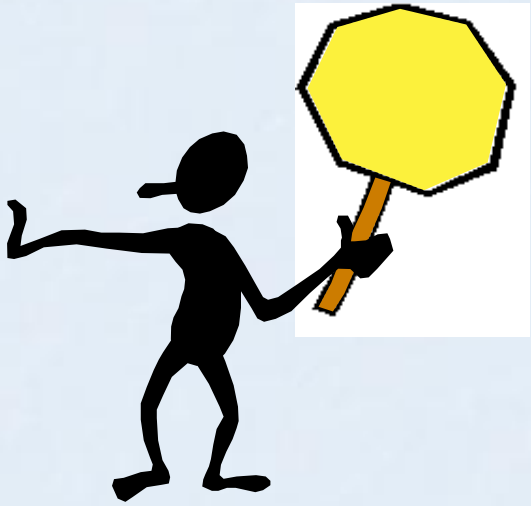
- CPT Codes 97802-97804
- 97802 = 8 unit maximum (2 hrs)
- 97804 = 6 unit maximum (2 hrs)
- Nonphysician Only
- RD
- Excluded with ESRD Services

Caution Note

- Dietician may bill MNT

  OR

- DSMT
- Not Both (NCCI edits)



Sample Pricing

- 97802(initial-15″) = $28.10
- 97803(sub-15″) = $24.56
- 97804(group-30″) = $12.54
- G0108 (individ. 30″) = $20.75
- G0109(group, ≥2) = $11.60

MNT CMS Reference

- http://www.cms.hhs.gov/Manuals/IOM/list.asp
- 100-03 Medicare National Coverage Determinations Manual
- Chapter 1, Part 3
- Section 180.1
- NCD 180.1

Evaluation and Management

- What?
  - CPT Codes 99xxx
- Who?
  - Physician management
  - Nonphysician practitioners
- Includes
  - Education/counseling

CERT

- Comprehensive Error Rate Testing
- #1 Error

Drum roll, please…
E/M!

New vs. Established Patient

- New patient to practice?
- Patient received professional services in the past 3 years?
  - Same physician or physician of same specialty in the practice
  - Covering or on-call physician

Decision Making-CPT Guidelines

- Number of DX/management options
- Amt/complexity of pertinent data
- Risk of complications
- Type of decision making

Contractor Perspective

Decision Making is #1

- Determine needs of patient based on CC
- Determine complexity of the visit
- Provide needed service, then document

Complex Visit

- Number of treatment options
- Number of pertinent diagnoses complicating treatment
- Amount/complexity of tests to diagnose problem
- Risk of significant complications

High-Level Visit Identification

- Complex patient with unexpected or unanticipated treatment response.
- Patient you worry about after the encounter.

Decision Making Pitfalls

- Diagnoses pertinent to episode
- Billing physician managing conditions
- Diagnostics medically necessary for current episode

End Stage Patients

- Identified terminal disease process
- Active treatment at end or palliative treatment
- Moderate E/M

Complex Stable Conditions

F/U vs. Complaint?

- New problem or exacerbation of an existing problem?
- Problem requires treatment change?
- Treatment change impacts other managed problems?
- Patient return date?

Preventive vs. Complexity

- No chief complaint
- Exam is not problem-oriented

99221-99223 Selection

- Planned or anticipated admission =

  low level

- Office visit + hospital admission =

  moderate - high level.

Consultation Requirements

- Document
  - Reason-specific request
  - Findings/Opinion
  - Communication to referring physician

Consults vs. Visits

- Consults answer a question
  - What is the diagnosis?
  - What is the treatment?
- Visits
  - Diagnosis is clearly defined
  - Transfer of care to another physician

POS Snafus

- Multiple visits on same DOS
- Code by the highest POS

E/M and Patient Teaching

- 50% rule
- Document teaching time
- Document reason for teaching
- Physician teaching only

Example of 50% Rule

- 99212-10 minutes
- 99213-15 minutes
- 99214-25 minutes
- 99215-40 minutes

- Patient exam
  - 9:10-9:15 (5 min)
- Patient education
  - 9:15-10:00 (45 min)
- Total of 50 minutes
- Correct Code: 99215

Reference: CPT

E/M Self-Audit Tool

	A	B	C	D	E	F
1	Code	Pro.Serv.	Formula	Pro. %	St. %	US %
2	99212	150	150/282	53%	16%	12%
3	99213	100	100/282	35%	56%	62%
4	99214	30	30/282	10%	26%	23%
5	99215	2	2/282	.7%	3%	3%
6	Total	282				

Self-Audit Tips

- Review E/M Guidelines
- Review/compare one day's cases
- Compare multiple physicians within your groups
- Visit web site for specialty comparison

Important Sites

- National Correct Coding
  - NCCI Edit information
  - http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP
- Fee Schedule
  - www.cms.hhs.gov/pfslookup

1995-1997 E/M Guidelines Sites

- http://www.cms.hhs.gov/MLNEdWebGuide
- www.CMS.hhs.gov (home)
- Medicare
- Outreach and Education
- MLN Education Web Guide
- Documentation Guidelines for E/M Services

E/M Code Comparisons

- PalmettoGBA.com
- South Carolina Part B
- E-M Help Center
- E/M Code Comparison

Contact Information

- Becke.Turner@Palmettogba.com
- Provider Contact Center – 1-888-828-2092

Handout – Palmetto GBA Medicare Part B Contacts

Questions?